Chapter Five

Medicaid Minimum Data Set Validation Program

Introduction The information in this chapter addresses the Medicaid Minimum Data Set Validation Program.

In This Chapter This chapter contains:

General Information

Background On October 1, 2004, the Division of Medical Assistance (DMA) began the Medicaid Minimum Data Set (MDS) Validation Program as a component of the Medicaid Case Mix Reimbursement System. All facilities participating in the Medicaid Case Mix Reimbursement System are required to participate in the MDS Validation Program. The overall goal of the Case Mix Reimbursement System is to align payments to the facility based on the resources utilized by the residents in the facility. Accurate completion of the MDS assessment is a very important function of the nursing facility staff and ensures that the nursing facility receives correct payments from the N.C. Medicaid Program.

The MDS Validation Program provides DMA and the nursing facility with assurance that Medicaid payments are accurately based on the recorded medical and functional needs of the nursing facility resident as documented in the medical record. The MDS Validation Program replaces the FL2 utilization review program performed by the facility staff and contract physicians. The Utilization Review Program was discontinued as of September 30, 2003.

DMA has contracted with Myers and Stauffer, LLP, to provide registered nurse reviewers who conduct onsite MDS reviews at each nursing facility in North Carolina annually.

The reviews began October 1, 2004. The first year of reviews was completed on September 30, 2005. The first year of reviews is considered as educational so that facility staff can learn the process and requirements for MDS supportive documentation.

Definitions

RUG III Reimbursement System

North Carolina Medicaid uses the 34 Grouper RUG-III system to assign the facility Case Mix Index (CMI) rate. The residents in the facility are classified into one of 34 groups based on the quantities of resources utilized. Resources are defined as nursing time, therapy time, and nursing assistant time. The RUG-III classification is based on accurate information from the MDS.

Case Mix

Case Mix refers to the combination of different individual resident profiles seen in a specific setting or nursing facility.

Case Mix Index

The Case Mix Index (CMI) is the "weighted" numeric score assigned to each RUG-III group. The weight is assigned based on the resources used to provide care to the resident. The higher the CMI, the greater the resource requirement for the resident.

Resident Roster

The Resident Roster is a list of all non-discharged residents that includes information on the MDS RUG-III elements transmitted on the sample set of assessments. In addition, it provides a summary of the number of MDS records in each RUG-III category.

Case Mix Supportive Documentation Guidelines

The Case Mix Supportive Documentation Guidelines approved by DMA identify the supporting documentation that is necessary to verify specific MDS information.

Medicaid MDS Validation Program

Protocols

1. The resident roster is produced on the CMI Report every quarter on the "snapshot date" and sent to the facility. The "snapshot dates" are March 31, June 30, September 30, and December 31. The review sample is drawn from the CMI report two quarters prior to the date of the review. For a facility review occurring in October, the review sample is drawn from the CMI report dated June 30. For a facility review occurring in February, the review sample is drawn from the CMI report dated September 30.

2. The sample is drawn from all residents listed on the final CMI report regardless of payer source.

3. Both the primary and expanded samples include a minimum of 80 percent Medicaid recipients.

Continued on next page

Medicaid MDS Validation Program, continued

Protocols (continued)

4. An expanded review is done when the primary assessment sample results indicate that unsupported MDS items are greater than the state threshold. The expanded review includes an additional 10 percent of the residents on the final CMI report or an additional 10 assessments, whichever is greater.

5. The findings of the MDS Validation Program may result in recalculating the RUG-III scores, causing a change in the case mix index rate for the nursing facility. If the CMI differs from the value transmitted for N.C. Medicaid payment, a retrospective rate adjustment may be applied.

MDS Validation Reviews

MDS Review Process

1. Nursing facilities are notified by the contract nurse reviewer by phone and by fax three business days prior to the review.

2. An entrance conference is held with the nursing facility administrator, the MDS coordinator, and any other facility personnel the administrator selects to discuss the overall objectives of the review and to allow facility personnel to ask questions.

3. The nurse reviewer prepares a list of the MDSs and resident records selected for review. Facility personnel pull the records immediately. If possible, the primary sample contains at least one assessment from each of the seven RUG-III classification groups.

4. The review begins immediately after the entrance conference. The reviewers use the most current version of the Case Mix Supportive Documentation Guidelines to validate MDS items.

5. The reviewer verifies the MDS items on each record and determines if the RUG-III category assigned on the Final Case Mix Report is supported with documentation.

6. Documentation for the Activities of Daily Living (ADL's) must reflect 24/7 of the observation periods to verify the submitted values on the MDS.

7. Immediately following the review of the MDS assessments, the medical records, and other supportive documentation, the nurse reviewers hold an exit interview with the facility staff to go over preliminary results. Any unresolved issues or trends are identified and discussed.

8. No supporting documentation is accepted after the close of the exit conference.

9. A case mix review summary letter is mailed to the provider by the nurse reviewers from Myers and Stauffer indicating any changes to the CMI that were made as a result of the review. If the facility disagrees with the findings of the review, a reconsideration review may be requested.

10. DMA reserves the right to conduct follow-up reviews as needed. These reviews occur no earlier than 120 days following the exit interview.

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MDS Validation Reviews, continued

Delinquent MDS Assessments

Any assessment with an R2b date greater than 121 days from the previous R2b date is deemed delinquent and assigned a RUG-III code of BC1 with the lowest possible case mix score.

Unsupported MDS Assessments

The MDS is unsupported when the MDS nurse reviewer does not find adequate documentation in the resident's record as defined by the guidelines issued by DMA to support the RUG-III classification level. An unsupported MDS assessment may result in a different RUG-III classification from the one submitted by the facility.

Effect of Unsupported Thresholds

1. First year of program – October 1, 2004 through September 30, 2005 – No penalties for unsupported MDS items.

2. Second year of program – October 1, 2005 through September 30, 2006 – 40 percent unsupported MDS values will result in re-rugging all unsupported MDS assessments and a recalculation of the direct rate. There may also be a retrospective rate adjustment.

3. Third year of program – October 1, 2006 through September 30, 2007 – 35 percent unsupported MDS values will result in re-rugging of all MDS assessments and a recalculation of the direct rate. A retrospective rate adjustment may also be applied.

4. Fourth year of program – October 1, 2007 through September 30, 2008 – 25 percent unsupported MDS values will result in the recalculation as indicated above.

MDS Validation Review Reconsideration

A reconsideration review may be requested if a facility disagrees with the findings of the Medicaid MDS Validation review. The procedure is as follows:

1. A summary letter of the review findings is sent by the nurse reviewer to the facility within 10 business days of the exit conference date.

2. If the facility disagrees with the findings, a written request for a Reconsideration Review is sent to DMA within 15 business days of the receipt of the MDS validation findings letter. The request is sent to the DMA Facility Services Unit Manager, 2501 Mail Service Center, Raleigh, NC 27699-2501. The letter to DMA must describe in detail the reason a reconsideration review has been requested.

3. DMA reviews the findings in question and renders a decision. This decision is sent in writing from DMA to the facility within 20 business days of the request for reconsideration.

4. If the facility disagrees with this decision, the facility can notify the DMA Facility Services Unit Manager within 10 days of receipt of the reconsideration decision. The information will be reviewed again by a neutral DMA staff member. A final decision is rendered in writing to the facility within 30 days.

Resources

Contact Information

MDS State Contact – for all questions related to coding on the MDS:
NC MDS Coordinator
Division of Facility Services
919-715-1872, ext. 214

MDS Help Desk
919-715-1872
QUIESHELPDESK@ncmail.net

Myers and Stauffer's Help Desk – For questions other than MDS coding issues and Case Mix Supportive Documentation Guidelines:
1-800-763-2278

Medicaid MDS Validation Program Oversight and Administration
Facility Services Unit Manager
DMA 919-855-4350